EXHIBIT 24

Gabriel
Minimally Invasive & General Surgery

740 Veterans Highway, Suite 306 • Hauppauge, NY 11788
Phone (631) 650-7580 • Fax (631) 650-7581

365 County Road 39A, Suite 11 • Southampton, NY 11968
Phone (631) 591-3992 • Fax (631) 591-0206

1 (888) 4WT-GOAL • www.gabrielsurgery.com

09/10/2014

1 877 761 7447

T[Redacted] S[Redacted]
[Redacted]
[Redacted] NY[Redacted]

Re: **REQUEST FOR ASSIGNMENT OF BENEFIT**

Our Client/Provider:	Nick Gabriel, D.O.
Patient:	T[Redacted] S[Redacted]
Date of Service:	3/27/13
Total Billed Charges:	$1,500.00
Total Payments Received:	$ 0.00
Balance Billed Amount:	$ 1,500.00

9/13/14 in network

Dear T[Redacted] S[Redacted]

Enclosed please find an Assignment of Benefits form ("AOB"), which we ask that you sign and return to us at your earliest convenience. Your health plan has either denied the above claims outright or paid them at unreasonably low reimbursement rates. We are seeking proper payment of these claims from your health plan, and in order to have legal standing to do so, we need a signed AOB from you.

As you may be aware, Dr. Gabriel is an out-of-network physician. Dr. Gabriel has submitted medical claims to your health plan for services provided to you on the date (s) of service (s) listed above. Two levels of appeal have also been submitted to your health plan on all claims, but have had little success and balances remain outstanding.

You may have received a balance billed letter either from our revenue recovery company, The Patriot Group, or from our attorneys, The Force Law Firm PC. They are working with us to pursue this balance from your health plan, and that is why we are requesting your cooperation. We wish to assure you that no collections activity against you has taken place, and neither Dr. Gabriel, nor his attorneys, nor The Patriot Group, has taken any action that could affect or jeopardize your credit report or history. Both State and Federal law require out-of-network providers to balance bill their patients the difference between charges and payments, and as such, you have received a Statement for the Balance Billed amount.

If your health plan has told you that Dr. Gabriel is in-network, and if the service occurred on or after 9/1/12, then they are giving you incorrect information. I attach correspondence from an

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executive of UHC/Oxford indicating that Dr. Gabriel is out-of-network/non-participating for all lines of business as of that date.

If I can be any further assistance, kindly contact me at 631-255-3503 or by email at nicoledisunno@optonline.net. We can provide you with copies of the two levels of appeal referenced above, information about Dr. Gabriel's efforts to recover payment from your health plan, and further information regarding the AOB form. We can also answer any other questions you may have about the circumstances that pertain to claims for services rendered to you by Dr. Gabriel.

We appreciate your being a patient of Dr. Gabriel and we will continue to advocate on behalf of you, his patients.

Sincerely,

Nicole DiSunno
Practice Manager

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Thomas Force

From: Thomas Force <tforce@forcelaw.net>
Sent: Saturday, December 17, 2011 3:36 PM
To: 'Pogany, Jeff'
Cc: Beale, Monique
Subject: RE: Termination of Dr. Nick Gabriel, DO

We do not agree that the contract you referenced was in effect as we take the position that it was terminated when Dr gabriel left the employ of Penninsula Hospital. You may do what you must or take the position you must, but we, on behalf of Dr Gabriel, reserve all of our rights and defenses with respect to his status as a non-participating provider, including, but not limited to litigation.

Tom

Thomas Force

The Force Law Firm P.C.
2 West Main Street-Suite 2
Bayshore, New York 11706
(631) 665-1832 EXT 5 -telephone
(631) 871-9284 -cellular
(631) 665-1881 -facsimile

tforce@forcelaw.net

From: Pogany, Jeff [mailto:jpogany@uhc.com]
Sent: Friday, December 16, 2011 2:56 PM
To: Thomas Force
Cc: Beale, Monique
Subject: Termination of Dr. Nick Gabriel, DO

Mr. Force,

I have received your letter requesting the termination of Dr. Gabriel's contract effective immediately. Per page 5 in the attached contract on file for Dr. Nick Gabriel, "...either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing 90 days' written or electronic notice..." According to the signature page, the Agreement went effective September 1, 2008. Based on the date of receipt of your letter (attached) titled "Termination of Provider Agreement for Dr. Nick Gabriel, DO", Dr. Nick Gabriel will be considered a Non-Participating Provider as of September 1, 2012 from all lines of business under UnitedHealthcare and Oxford.

Thank you,

Jeff Pogany
Manager, Physician Contracting for Suffolk/Nassau/Richmond
UnitedHealthcare
One Penn Plaza, 8th Fl.
New York, NY 10119
Email: jpogany@uhc.com
Phone: 212-216-6609
Fax: 877-842-7868

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute and necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date